Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: AUGUST 25, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Physical Therapy X8 sessions (97140, 97110, 97112, 97530, 97035, 97010, G0283)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by Chiropractor licensed by the Texas State Board of Chiropractic Examiners. The reviewer specializes in Chiropractic and is engaged in the full time practice of medicine. The Chiropractor is Board certified in Pain Management, Quality Assurance, and Acupuncture. (NBCE) The Chiropractor is a Designated Doctor certified to perform Impairment Ratings.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
726.10, 840.9	97140		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	97110		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	97112		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	97530		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	97035		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	97010		Prosp	8			Xx/xx/xx	xx	Upheld
726.10, 840.9	G0283		Prosp	8			Xx/xx/xx	xx	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This female patient was injured on xx/xx/xx while reportedly lifting. She injured her right shoulder, and received physical therapy totaling 12sessions. Her last 6 sessions of PT were completed after a shoulder injection.
On xxxx, range of motion of the right shoulder was noted to be 180 of flexion, 160 of abduction, and 90+ degrees of internal and external rotation.
On xxxxx noted that this patient did not want surgery, and she was working light duty, and would be off work for the summer.
On xxxxxx, noted that ranges of motion and orthopedic testing were normal or within normal limits. He also noted that she was "doing well as far as range of motion and strength" and that "she needs more strengthening even though she has adequate strengthening now." The only positive finding was mild tendernessover the anterior subacromial region. released her from his care on this date, xxxxxx. There are no other clinical findings in support of this request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

There are no significant documented functional deficits which remain to be addressed by continued supervised physical therapy. The claimant has had the opportunity for treatment and orthopedic evaluation. According to the clinical history and course, and congruent with ODG guidelines, this claimant has received adequate and appropriate treatment. There are no co-morbidities or other factors which would support treatment beyond guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG TWCShoulder Injuries states: (updated5/26/15)

"Physical Therapy: ODGPhysical Therapy Guidelines –

Allowfor fading of treatment frequency (from up to 3 visits per week to 1 or less),plus active self-directed home PT. Alsosee other general guidelines that apply to all conditions under PhysicalTherapy in the ODG Preface.
Rotatorcuff syndrome/Impingement syndrome (ICD9726.1; 726.12):
Medicaltreatment: 10 visits over 8 weeks
Post-injectiontreatment: 1-2 visits over 1 week
Post-surgicaltreatment, arthroscopic: 24 visits over 14 weeks